X2017-1064

PRINTED: 07/07/2017
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504002	A. BUILDING _____ B. WING _____	06/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BHC FAIRFAX HOSPITAL	10200 NE 132ND STREET KIRKLAND, WA 98034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 000	INITIAL COMMENTS STATE LICENSING SURVEY The Washington State Department of Health (DOH) in accordance with Washington Administrative Code (WAC), Chapter 246-322, Private Psychiatric and Alcoholism Hospitals, conducted this health and safety survey. Onsite dates: 06/27/17 to 06/29/17 Examination number: 2017-1064 The survey was conducted by: Lisa Mahoney, MPH, PHA Joyce Williams, RN, BSN The Washington Fire Protection Bureau conducted the fire life safety inspection on 06/27/17.	L 000	1. A written PLAN OF CORRECTION is required for each deficiency listed on the Statement of Deficiencies. 2. EACH plan of correction statement must include the following: The regulation number and/or the tag number; HOW the deficiency will be corrected; WHO is responsible for making the correction; WHAT will be done to prevent reoccurrence and how you will monitor for continued compliance; and WHEN the correction will be completed. 3. Your PLANS OF CORRECTION must be returned within 10 business days from the date you receive the Statement of Deficiencies. Your Plans of Correction must be postmarked by July 21, 2017. 4. Return the ORIGINAL REPORT with the required signatures.	
L 455	322-040.8A ADMIN RULES-STAFF WAC 246-322-040 Governing Body and Administration. The governing body shall: (8) Require and approve professional staff bylaws and rules concerning, at a minimum: (a) Organization of the professional staff; This RULE: is not met as evidenced by: Based on document review and interview, the hospital governing board failed to review and	L 455	RECEIVED JUL 24 2017 DEPARTMENT OF HEALTH Office of Investigation and Inspection	

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Rhonda TITLE CEO (X6) DATE 7/21/17

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L 455	Continued From Page 1 approve the Medical Staff Bylaws. Failure to maintain oversight and approval for the rules and bylaws of the Medical Staff puts patients at risk of substandard care due to lack of oversight. Findings included: 1. During review of the hospital's medical staff bylaws (dated May 2009), Surveyor #1 observed that the signature page of the document had no signatures indicating Governing Body approval. 2. On 06/29/17 at 10:30 AM, the hospital's medical staff credentialist (Staff C) stated that she was unable to locate a signed copy of the document and she was unable to locate any reference to the approval of the bylaws in the minutes of the Governing Body.	L 455		
L 725	322-100.1H INFECT CONTROL-EMPLOYEE WAC 246-322-100 Infection Control. The licensee shall: (1) Establish and implement an effective hospital-wide infection control program, which includes at a minimum: (h) Coordinating employee activities to control exposure and transmission of infections to or from employees and others performing patient services; This RULE: is not met as evidenced by: Based on observation, interview and review of hospital policy and procedures, the hospital failed to ensure that staff members performed appropriate hand hygiene (HH) during wound care and dressing changes.	L 725		

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L 725	Continued From Page 2 Failure to perform hand hygiene during wound care and dressing changes risks transmission of infectious diseases to patients and caregivers. Findings Included: 1. The hospital's policy and procedure titled, "Hand Hygiene", Policy # 1600.4.4 revised 3/2017, showed that employees were to wash hands thoroughly before and after each individual patient contact. 2. On 06/27/17, Surveyor #2 observed a registered nurse (RN) (Staff D) on 1-West change a dressing covering a wound on a patient's hand. The RN did not perform HH prior to donning his gloves. He changed the dressing, discarded the soiled bandage and proceeded to touch the door handle of the nurses' station, the door handle of the medication room and the glass window in the medication room while still wearing his contaminated gloves. He removed the gloves, but failed to perform hand hygiene afterward. 3. The Director of Nursing (Staff E) observed the dressing change with Surveyor #2. She acknowledged that the RN failed to perform appropriate HH and potentially cross-contaminated areas he touched prior to removing gloves.	L 725		
L 780	322-120.1 SAFE ENVIRONMENT WAC 246-322-120 Physical Environment. The licensee shall: (1) Provide a safe and clean environment for patients, staff and visitors; This RULE: Is not met as evidenced by:	L 780		

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L 780	Continued From Page 3 Based on observation and interview, the hospital failed to maintain and clean storage areas for patient items. Failure to clean and maintain storage areas for patient items put patients at risk from an unclean, unsafe environment. Findings included: 1. On 06/27/17 at 10:25 AM, Surveyor #1 toured unit 2-West with the Director of Performance Improvement (Staff A) and a member of the Facilities Department (Staff B). The observation showed excessive amounts of dirt and debris in a hallway storage closet. 2. On 06/27/17 at 10:30 AM, Surveyor #1 toured unit 2-West with the Director of Performance Improvement (Staff A) and a member of the Facilities Department (Staff B). The observation showed an overflowing bin of clothes spilled out into a hallway storage closet. Staff Member A stated that the clothes were items received as donations for patient use, but that no one had sorted through them so they were temporarily stored in one of the unit's closets.	L 780		
L1055	322-170.2C EXAM & MEDICAL HISTORY WAC 246-322-170 Patient Care Services. (2) The licensee shall provide medical supervision and treatment, transfer, and discharge planning for each patient admitted or retained, including but not limited to: (c) A physical examination and medical history completed and recorded by a physician, advanced registered nurse practitioner, or physician	L1055		

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L1055	Continued From Page 4 assistant within twenty-four hours following admission, unless the patient had a physical examination and medical history completed within fourteen days prior to admission, and the information is recorded in the clinical record; This RULE: is not met as evidenced by: Based on interview, medical record review and hospital policy and procedure, the hospital failed to ensure that providers completed an initial history and physical examination within 24 hours of admission. Failure to perform an initial history and physical examination within 24 hours of admission risks serious harm to patients if medical conditions are not identified and treated. Findings include: 1. The Hospital policy and procedure titled, "Admission Assessment of Patients" Policy #2061 revised 1/17 showed that a history and physical examination will be completed within 24 hours of admission by a physician, Advanced Registered Nurse Practitioner (ARNP) or Certified Physician Assistant (PA-C). 2. Surveyor #2 reviewed the medical record of an adolescent. Patient#3, was admitted on 05/18/17. On 05/19/17, an ARNP (Staff I) attempted to complete the initial history and physical; however, the ARNP noted the patient was not able to cooperate due to mental status. On 06/9/17, (3 weeks later), a second ARNP (Staff J) performed the physical examination. 3. On 06/27/17 at 11:00 AM, Surveyor #2 discussed this finding with the Risk Manager (Staff	L1055		

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L1055	Continued From Page 5 H). He acknowledged that a History and Physical should have been attempted and completed sooner than 3 weeks after admission.	L1055		
L1150	322-180.1D PHYSICIAN AUTHORIZATION WAC 246-322-180 Patient Safety and Seclusion Care. (1) The licensee shall assure seclusion and restraint are used only to the extent and duration necessary to ensure the safety of patients, staff, and property, as follows: (d) Staff shall notify, and receive authorization by, a physician within one hour of initiating patient restraint or seclusion; This RULE: Is not met as evidenced by: Based on an interview and review of medical records, the hospital failed to ensure that physicians provided the date and time for orders for restraint/seclusion and that the ordering provider's name was included in the order. Failure to ensure that physicians appropriately document, date and time restraint/seclusion orders risks patients' rights violations as well as patient injury. Findings Included: 1. During discharged record review, Surveyor #2 reviewed the seclusion/restraint discontinuation evaluation for patient #1. The Registered Nurse (RN) (Staff F) documented that the staff notified the attending provider on 06/21/17 of discontinuation of restraint but she failed to note the name of the provider and the time the provider received notification.	L1150		

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L1150	Continued From Page 6 2. Surveyor #2 reviewed the Seclusion/Restraint Order for Patient #2. A RN (Staff G) wrote and signed the order on 04/16/17 at 5:00 PM. It was written as a telephone order with the "read back completed" checked by the RN; however, the name of the provider was missing on the order and the provider had not authenticated the order. 3. On 06/29/17 at 9:30 AM, Surveyor #2 discussed this finding with the Risk Manager (Staff H). He acknowledged the providers' names were not listed, time of contact with the providers was missing and the provider had not signed off on the order to authorize it.	L1150		
L1485	322-230.1 FOOD SERVICE REGS WAC 246-322-230 Food and Dietary Services. The licensee shall: (1) Comply with chapters 246-215 and 246-217 WAC, food service; This RULE: is not met as evidenced by: Based on observation and interview, the hospital failed to maintain the cold-holding temperature of refrigerated items in compliance with the Washington State Retail Food Code (WAC) 246-217. Failure to maintain compliance with the Washington State Retail Food Code puts patients at risk from food-borne illnesses. Findings included: On 06/27/17 at 11:00 AM, Surveyor #1 used a thin stemmed thermometer to assess the internal temperature of foods in the 1-West kitchen refrigerator. The item selected (commercial	L1485		

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L1485	Continued From Page 7 yogurt) measured 51 degrees Fahrenheit, above the maximum cold-holding temperature of 41 degrees Fahrenheit. At the time of the initial observation, a member of the Facilities Department (Staff B) stated that staff members might have just restocked the unit. On 06/27/17 at 11:55 AM, the surveyor again assessed the internal temperature of an item in the unit (milk container). The item measured 50 degrees Fahrenheit. Staff B placed a work order for repair at the time of the second temperature check. Ref: Washington State Retail Food Code (WAC 246-215-03525 (1)(b)	L1485		